

WORKSITE SCREENING

Request Form

Please complete this screening request form when you have determined the date, time, location and number of employees who wish to be screened at your worksite. Return the completed form to Prevention Partners 6 weeks before your proposed screening date.

Your Name:		
Worksite Name:		
Worksite Address:		
City:	State:	Zip:
Telephone:	FAX Number:	E-mail Address:
Location of Screening (Please include room name or number and attach directions if necessary):		
Screening Provider: <input type="checkbox"/> Same as last year/last screening <input type="checkbox"/> Please assign a different provider from the one that did my last screening <input type="checkbox"/> This is my first screening <input type="checkbox"/> Special requests/Comments: _____ _____		
Proposed Dates of Screening:		
1 st Choice _____ 2 nd Choice _____ 3 rd Choice _____		
Starting Time:	Expected Number of Participants:	
Signature:		Date:
Does your worksite have a <input type="checkbox"/> No Prevention Partners coordinator? <input type="checkbox"/> Yes — Name: _____		
<p style="text-align: center;">Mail or FAX completed form to: Prevention Partners Employee Insurance Program 1201 Main Street, Suite 300 Columbia, SC 29201</p> <p>Telephone: (803) 737-3820 FAX: (803) 737-0557</p>		

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PREVENTION PARTNERS